2020 Schedule of Benefits

	HMO Benefits	POS Benefits		HDHP Benefits	
	Network	Network	Non-Network	Network	Non-Network
Benefit Period Deductible (Single/Family)	$500/$1,500	$500/$1,500	$1,000/$3,000	$2,000/$4,000	$4,500/$9,000
Out of Pocket Maximum (Single/Family)	$2,500/$5,000	$2,500/$5,000	$6,000/$12,000	$2,000/$4,000	$8,500/$17,000
Physicians Office Visit	$25.00 per visit	$25.00 per visit	70%/30%	100% after deductible	70% after deductible
Specialist Office Visit	$35.00 per visit	$35.00 per visit	70%/30%	100% after deductible	70% after deductible
Allied Health Professionals					
Chiropractor	$25.00 per visit	$25.00 per visit	70%/30%	100% after deductible	70% after deductible
Physician's Assistant	$25.00 per visit	$25.00 per visit	70%/30%	100% after deductible	70% after deductible
Rehabilitative Care	80%/20%	80%/20%	70%/30%	100% after deductible	70% after deductible
Preventive/Wellness	$0	$0	70%/30%	0%	70%/30%
Employee Assistance Counseling	3 Visits (No Copay/Coinsurance)	3 Visits (No Copay/Coinsurance)	70%/30%	100% after deductible	70% after deductible
Urgent Care Center	$40.00 per visit	$40.00 per visit	70%/30%	100% after deductible	70% after deductible
Vision Care Exam (1 per 24 Months)	$35.00 per visit	$35.00 per visit	$35.00 per visit	Not Covered	Not Covered
Refractive Errors of Eye	50%/50%	50%/50%	Not Covered	Not Covered	Not Covered
Emergency Room	$150 (waived if admitted)	$150 (waived if admitted)	$150 (waived if admitted)	100% after deductible	70% after deductible
Ambulance Services	$100 per day per Provider	$100 per day per Provider	70%/30%	100% after deductible	70% after deductible
Air Ambulance Services	$200 per day per Provider	$200 per day per Provider	70%/30%	100% after deductible	70% after deductible
Ambulatory Surgical Facility	$200 per Surgical visit	$200 per Surgical visit	70%/30%	100% after deductible	70% after deductible
Physicians Outpatient Surgical Services	$100 Copay per Day	$100 Copay per Day	70%/30%	100% after deductible	70% after deductible
Inpatient Hospital Admission	$200 per day/5 day Max	$200 per day/5 day Max	70%/30%	100% after deductible	70% after deductible
Pregnancy Care	$50 Copay (first visit only)	$50 Copay (first visit only)	70%/30%	100% after deductible	70% after deductible
Durable Medical Equipment	80%/20% ($25,000 max)	80%/20% ($25,000 max)	70%/30%	100% after deductible	70% after deductible
Home Health Care	100%	100%	70%/30%	100% after deductible	70% after deductible
Hospice (limit 185 days)	100%	100%	70%/30%	100% after deductible	70% after deductible
Skilled Nursing Facility (limit 100 days)	100%	100%	70%/30%	100% after deductible	70% after deductible
Speech Therapy	80%/20%	80%/20%	70%/30%	100% after deductible	70% after deductible
Organ, Tissue, and Bone Marrow Trans.	Same as any other illness	Same as any other illness	None	100% after deductible	70% after deductible
Mental Disorders/Alcohol/Drug Abuse					
Outpatient Mental Health and Substance Abuse Benefits	100%	100%	70%/30%	100%	70%
Inpatient Mental Health and Substance Drug Abuse Benefits	100%	100%	70%/30%	100%	70%
Inpatient Hospital Copayments and/or Inpatient Coinsurance amounts for Mental Health and Substance Abuse	Payable same as medical benefits	Payable same as medical benefits	Payable same as medical benefits	Payable same as medical benefits	Payable same as medical benefits
Prescription Drug (Generic & Brand)	See attached Prescription Plan for HMO and POS			100 % after deductible	

****This is not intended to be comprehensive. The terms and conditions of the contract will prevail.****